



*Social Security number required pursuant to IC 4-1-8-1.

*** THIS FORM IS FOR ENDORSEMENT CANDIDATES ONLY.**

THIS SECTION IS TO BE COMPLETED AND AUTHORIZED BY THE STATE BOARD			
<input type="checkbox"/> Yes <input type="checkbox"/> No		The individual referred to above completed an administrator-in-training program for licensure in our state. <i>(If yes, complete the section below.)</i>	
Name of facility where training took place		Length of training program	
		months	hours
Address <i>(number and street, city, state, ZIP code)</i>			
Preceptor / Supervisor of training program			
Type of facility		Please affix Board seal	
Form completed by <i>(printed name)</i>			
Title			
Signature	Date <i>(month, day, year)</i>		